NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

CHILDREN'S HEALTH INSURANCE PROGRAM

PREAMBLE

1. Sections Affected | **Rulemaking Action**

R9-31-201	Amend
R9-31-212	Amend
R9-31-216	Amend
R9-31-1611	Amend

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: ARS § 36-2903.01 (F)

Implementing statute: ARS § 36-2989

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Docket Opening: 12 A.A.R. 1424, April 28, 2006

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Administrative and Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

5. An explanation of the rule, including the agency's reasons for initiating the rule:

The Administration must revise rules to comply with the Consent Decree mandating the coverage of incontinence briefs as a preventive measure to certain EPSDT AHCCCS members who are incontinent as a result of their disabilities.

6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on in its evaluation of or justification for the rule or proposes not to rely on in its evaluation of or justification for the

rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

No study was reviewed or considered for this rulemaking.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable.

8. The preliminary summary of the economic, small business, and consumer impact:

This rulemaking is anticipated to have a minimal to moderate economic impact on the involved parties. Affected members will benefit from the added coverage of incontinence briefs. Additional costs will be incurred by the Administration and the contractors for coverage of these supplies.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name:	Mariaelena Ugarte
Address:	AHCCCS
	Office of Administrative and Legal Services
	701 E. Jefferson, Mail Drop 6200
	Phoenix, AZ 85034
Telephone:	(602) 417-4693
Fax:	(602) 253-9115
E-mail:	AHCCCSRules@azahcccs.gov

Proposed rule language will be available on the AHCCCS website www.azahcccs.gov the week of April 2, 2007. Please send written comments to the above address by 5:00 p.m., May 21, 2007. E-mail comments will be accepted.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date:	May 21, 2007
Time:	10:00 a.m.
Location:	AHCCCS
	701 East Jefferson
	Phoenix, AZ 85034
Nature:	Public Hearing

Date:	May 21, 2007
Time:	10:00 a.m.
Location:	ALTCS: Arizona Long-Term Care System
	110 South Church, Suite 1360

	Tucson, AZ 85701
Nature:	Public Hearing
Date:	May 21, 2007
Time:	10:00 a.m.
Location:	ALTCS: Arizona Long-Term Care System
	3480 East Route 66
	Flagstaff, AZ 86004
Nature:	Public Hearing

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

12. Incorporations by reference and their location in the rules:

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

CHILDREN'S HEALTH INSURANCE PROGRAM

Article 2. SCOPE OF SERVICES

Section

Article 16. SERVICES FOR NATIVE AMERICANS

Section

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

CHILDREN'S HEALTH INSURANCE PROGRAM

ARTICLE 2. SCOPE OF SERVICES

R9-31-201. General Requirements

A. The Administration shall administer the Children's Health Insurance Program under A.R.S. § 36-2982.

B. Scope of Services for Native American fee-for-service members is under Article 16 of this Chapter.

C. A contractor or RBHA shall provide behavioral health services under Article 12 and Article 16.

D. In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:

1. Only medically necessary, cost effective, and federally- reimbursable and state-reimbursable services are covered services.
2. The Administration or a contractor may waive the covered services referral requirements of this Article.
3. Except as authorized by a contractor, a primary care provider, practitioner, or dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
4. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.
5. A member may receive behavioral health evaluation services without a referral from a primary care provider. A member may receive behavioral health treatment services only under referral from the primary care provider, or upon authorization by the contractor or the contractor's designee.
6. A member may receive treatment that is considered the standard of care, or that is approved by the AHCCCS Chief Medical Officer after appropriate input from providers who are considered experts in the field by the professional medical community.
7. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.
8. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
    a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research,
    b. Services or items furnished gratuitously, and
    c. Personal care items, except as specified in R9-31-212.

9. Medical or behavioral health services are not covered if provided to:

   a. An inmate of a public institution;

   b. A person who is a resident of an institution for the treatment of tuberculosis; or

   c. A person who is in an IMD at the time of application, unless provided under Article 12 of this Chapter.

E. The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained under this Article and Article 7 of this Chapter. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.

F. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.

G. Under A.R.S. § 36-2989, a member shall receive covered services outside the GSA only if one of the following applies:

1. A member is referred by a primary care provider for medical specialty care out of the contractor's area. If the member is referred outside of the GSA to receive an authorized medically necessary service, a contractor shall also provide all other medically necessary covered services for the member;

2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member's family; or

3. The contractor authorizes placement in a nursing facility located outside of the GSA;

H. If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

I. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.

J. The restrictions, limitations, and exclusions in this Article do not apply to a contractor if the contractor elects to provide noncovered services.

1. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.

2. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.

R9-31-212. ~~Medical Supplies,~~ Durable Medical Equipment, ~~and~~ Orthotic and Prosthetic Devices, and Medical Supplies

~~A.~~ As specified in A.R.S. § 36-2989, ~~medical supplies,~~ DME, ~~and~~ orthotic and prosthetic devices, and medical supplies, including incontinence briefs, are covered services if provided in compliance with requirements of this Chapter and~~:~~ A.A.C. R9-22-212. Where the term AHCCCS services is used, replace it with Title XXI services.

~~1. Prescribed by the member's primary care provider, practitioner, or dentist;~~

~~2. Prescribed by a specialist upon referral from the primary care provider, practitioner, or dentist; and~~

~~3. Authorized by the contractor or the contractor's designee.~~

~~B. Covered medical supplies are consumable items that are disposable and are essential to a member's health.~~

~~C. Covered DME is any item, appliance, or piece of equipment that is:~~

~~1. Designed for a medical purpose,~~

~~2. To withstand wear,~~

~~3. Generally reusable by others, and~~

~~4. Purchased or rented for a member.~~

~~D. Covered prosthetic and orthotic devices are only those items that are essential for the habilitation or rehabilitation of a member.~~

~~E. The following limitations on coverage include:~~

~~1. DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased;~~

~~2. Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair is less than the cost of renting or purchasing another unit;~~

~~3. A change in, or addition to, an original order for DME is covered if approved by the member's primary care provider or authorized prescriber, or prior authorized by the contractor for a member, and the change or addition is indicated clearly on the order and initialed by the vendor. No change or addition to the original order for DME shall be made after a claim for services is submitted to a member's contractor, without prior written notification of the change or addition;~~

~~4. Reimbursement for rental fees shall terminate:~~

~~a. No later than the end of the month in which the primary care provider or authorized prescriber certifies that the member no longer needs the DME;~~

~~b. If the member is no longer eligible for AHCCCS services; or~~

~~c. If the member is no longer enrolled with a contractor, with the exception of transitions of care as specified by the Administration.~~

~~5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition and:~~

~~a. Prescribed by:~~

~~i. The member's primary care provider or practitioner, or~~

~~ii. A specialist upon referral from the primary care provider or practitioner; and~~

~~b. Authorized as required by the contractor or its designee;~~

~~6. First aid supplies are not covered unless they are provided in accordance with a prescription.~~

~~F. Liability and ownership.~~

~~1. Purchased DME provided to a member that is no longer needed may be disposed of in accordance with each contractor's policy.~~

~~2. If customized DME is purchased by the contractor for a member, the DME shall remain with the member during times of transition, or upon loss of eligibility.~~

~~a. For purposes of this Section, customized DME refers to DME that has been altered or built to specifications unique to a member's medical needs and that, most likely, cannot be used or reused to meet the needs of another individual.~~

~~b. A member shall return customized DME obtained fraudulently to the Administration or the contractor.~~

R9-31-216. NF, Alternative HCBS Setting, or HCBS

~~A.~~ Services provided in a NF, including room and board, alternative HCBS setting, or HCBS ~~as defined in R9-28-101, or HCBS as defined in R9-28-101 are covered for a maximum of 90 days per contract year if the member's medical condition would otherwise require hospitalization.~~ shall be covered as specified in A.A.C. R9-22-216.

~~B. Except as otherwise provided in 9 A.A.C. 28, the following services are not itemized for separate billing if provided in a NF, alternative HCBS setting, or HCBS:~~

~~1. Nursing services including:~~

~~a. Administering medication,~~

~~b. Tube feedings,~~

~~c. Personal care services (assistance with bathing and grooming),~~

~~d. Routine testing of vital signs, and~~

~~e. Maintenance of catheter.~~

~~2. Basic patient care equipment and sickroom supplies, including:~~

~~a. First aid supplies such as bandages, tape, ointment, peroxide, alcohol, and over-the-counter remedies;~~

~~b. Bathing and grooming supplies;~~

c. Identification device;

d. Skin lotion;

e. Medication cup;

f. Alcohol wipes, cotton balls, and cotton rolls;

g. Rubber gloves (non-sterile);

h. Laxatives;

i. Bed and accessories;

j. Thermometer;

k. Ice bags;

l. Rubber sheeting;

m. Passive restraints;

n. Glycerin swabs;

o. Facial tissue;

p. Enemas;

q. Heating pad; and

r. Diapers.

3. Dietary services including preparation and administration of special diets, and adaptive tools for eating;

4. Any service that is included in a NF's room and board charge or a service that is required of the NF to meet a federal mandate, state licensure standard, or county certification requirement;

5. Physician visits made solely for the purpose of meeting a state licensure standard or county certification requirement;

6. Physical therapy; and

7. Assistive device or non-customized DME.

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

R9-31-1611. ~~Medical Supplies,~~ Durable Medical Equipment, ~~and~~ Orthotic and Prosthetic Devices, and Medical Supplies

~~A. Medical supplies, DME~~ Durable medical equipment, ~~and~~ orthotic and prosthetic devices, and medical supplies, including incontinence briefs, are covered services if provided in compliance with the requirements of this Chapter~~;~~ and A.A.C. R9-22-212. Where the term AHCCCS services is used, replace it with Title XXI services. Where the term provider or contractor is used, replace it with IHS or Tribal facility.

~~1. Authorized by the Administration,~~

~~2. Prescribed by the IHS or Tribal Facility provider, or~~

~~3. Prescribed by a physician or a practitioner upon referral from the IHS or a Tribal Facility unless the referral is waived by the Administration.~~

~~B. Covered medical supplies are consumable items that are disposable and are essential to a member's health.~~

~~C. Covered DME is any item, appliance, or piece of equipment that is:~~

~~1. Designed for a medical purpose,~~

~~2. To withstand wear,~~

~~3. Generally reusable by others, and~~

~~4. Purchased or rented for a member.~~

~~D. Covered prosthetic and orthotic devices are only those items that are essential for the habilitation or rehabilitation of a member.~~

~~E. The following limitations on coverage apply:~~

~~1. DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased.~~

~~2. Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.~~

~~3. A change in, or addition to, an original order for DME is covered if approved by a member's IHS or a Tribal Facility provider or an authorized prescriber and the change or addition is indicated clearly on the order and initialed by a vendor.~~

~~4. Reimbursement for rental fees shall terminate:~~

~~a. No later than the end of the month in which the IHS or a Tribal Facility provider or an authorized prescriber certifies that the member no longer needs the DME,~~

b. If the member is no longer eligible for service through this program, or

c. If the member is no longer enrolled with the IHS with the exception of transitions of care as specified by the Administration.

5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition and:

a. Prescribed by:

i. The member's attending physician or practitioner, or

ii. A specialist upon referral from an IHS or tribal facility provider, and

b. Authorized as required by the Administration.

6. First aid supplies are not covered unless they are provided according to a prescription.

F. Liability and ownership.

1. Purchased DME provided to a member that is no longer needed may be disposed of as specified in the policy of the IHS or a Tribal Facility.

2. If customized DME is purchased for a member by the Administration, the DME shall remain with the member during times of transition, or upon loss of eligibility.

a. For purposes of this Section, customized DME refers to DME that has been altered or built to specifications unique to a member's medical needs and that, most likely, cannot be used or reused to meet the needs of another individual.

b. A member shall return customized equipment obtained fraudulently to the Administration.